Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THE SAN ANTONIO ORTHOPAEDIC GROUP
400 CONCORD PLAZA DRIVE SUITE 300
SAN ANTONIO TX 78216

Respondent Name

PACIFIC INDEMNITY CO

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-12-0041-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A corrected claim was sent to Chubb Ins on 11/15/2010 with Mod TC appended. We have resubmitted our claim several times for reconsideration, with no response via eob, or followup return phone calls to messages left."

Amount in Dispute: $1240.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2010	CPT code 73721-TC	$1240.71	$583.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §133.20, effective January 29, 2009 sets out requirements for submitting medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated November 1, 2010

- B20-Srvs partially/fully furnished by another provider.
- Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. David Lawrence Burk, Jr. MD is rendering HCP.

Issues

1. Did the respondent support position that another provider rendered the service?
2. Is the requestor entitled to reimbursement?

Findings

1. The disputed services were denied based upon reason code "B20-Srvs partially/fully furnished by another provider"; and "Per Rule 133.20(e)(2) a medical bill must be submitted in the name of the licensed HCP that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care. David Lawrence Burk, Jr. MD is rendering HCP."

   28 Texas Administrative Code §133.20(e) states "A medical bill must be submitted: (1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005; and (2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   CPT code 73721 is defined as "Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material". The requestor appended modifier TC-Technical component to CPT code 73721.

   Review of the submitted documentation finds that Dr. Burk interpreted the MRI; therefore, the requestors billing of 73721-TC for the technical component is not contradictory.

   The respondent did not support the denial of B20; therefore, reimbursement is recommended.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78229, which is located in Bexar County.

   The MAR for CPT code 73721-TC in Bexar County is $583.70. The respondent paid $0.00; therefore, the requestor is due $583.70.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $583.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $583.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order

Authorized Signature

		5/16/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.